

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-017731

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 381 Primary Registration District No. 6125 Registrar's No. 38

FILED MAY 7 1962

1. PLACE OF DEATH

a. COUNTY SULLIVAN

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN LIBERTY TOWNSHIP 1 YR.

Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTIONInside Limits
Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE MO b. COUNTY SULLIVAN

c. CITY OR TOWN MILAN (8 MILES NW)

Inside Limits
Yes ☐ No ☒

d. STREET ADDRESS (If outside, give location)

Reside on Farm
Yes ☒ No ☐3. NAME OF DECEASED
(Type or print)First Middle Last
EVERETT GLEN CALHOUN4. DATE OF DEATH Month Day Year
APRIL 27 19625. SEX
M6. COLOR OR RACE
W7. Married ☒ Never Married ☐
Widowed ☐ Divorced ☐8. DATE OF BIRTH
5-12-939. AGE (last birthday)
68IF UNDER 1 YEAR IF UNDER 24 HR
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

FARMER

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)
SULLIVAN CO. MO

12. CITIZEN OF WHAT COUNTRY

13a. FATHER'S NAME

MARION LEE CALHOUN

13b. MOTHER'S MAIDEN NAME

GERTRUDE EATON

14. NAME OF HUSBAND OR WIFE

EULA E CALHOUN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

YES - WWII

16. SOCIAL SECURITY NO.

17. INFORMANT

793 Eula Calhoun

Address

Milan, Mo

18. CAUSE OF DEATH (Enter only one cause per line)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CORONARY OCCLUSION

INTERVAL BETWEEN ONSET AND DEATH

10 MIN

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☐20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from _____ to _____ and last saw him/her alive on _____
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

INSTEAD OF

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF

VS 300
Rev. 4/59

1 1050

2 1050

3

4 0

5 1

6

7 0

8 0

9 4201

10

11

12 90-2

13 2-0

MAY 8 1962

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 3792

P. O. Address 

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.